

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/22/2016  
FORM APPROVED  
OMB NO 0938-0391

45# 3/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/10/2016
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NAME OF PROVIDER OR SUPPLIER  DURHAM-HENSLEY HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 55 NURSING HOME RD CHUCKEY, TN 37641
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 371  
SS=F

483.35(i) FOOD PROCURE,  
STORE/PREPARE/SERVE- SANITARY

The facility must-

- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
- (2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:

Based on facility policy review, observation, and interview, the facility failed to maintain a sanitary environment in 2 of 2 kitchen observations made.

The findings included:

Review of facility policy Pots and Pans Hot Water, not dated, revealed "...when items are dry, store in proper storage area..."

Review of facility policy Dishwashing Procedure, not dated, revealed "...clean and soiled dishes, utensils and pot and pans must be separated..."

Observation with the Dietary Manager (DM) on 2/8/16 at 9:05AM, in the kitchen, revealed 4 full size baking sheets were stored wet on a clean and ready to use equipment shelf. Continued observation revealed dietary manuals were stored in a cabinet with drinking glasses.

Interview with the DM on 2/8/16 at 9:10AM, in the kitchen, confirmed the baking sheets were stored wet on an equipment shelf and were available for

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Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Durham-Hensley Health and Rehabilitation of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Durham-Hensley Health and Rehabilitation files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through Informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.

Corrective Actions for Targeted Residents

Facility Residents have shown no outward ill-effects from cited practice. Dietary Manuals stored in the cabinet with drinking glasses were removed by the Dietary Manager on 2/8/16. Wet baking sheets were re-washed, thoroughly air-dried, and returned to the clean equipment shelf by the DM on 2/8/16. Process for maintaining clean and soiled dishes in separate areas, by preventing clean dishes from being transported through the dirty dish area, was initiated by the DM on 2/10/16; as well as providing education to Dietary Staff on duty for carrying out this process.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Kathie H. Ball*

*Administrator*

3-2-16

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 371	<p>Continued</p> <p>use. Continued interview confirmed the dietary manuals should not be stored with the clean drinking glasses.</p> <p>Observation on 2/8/16 at 11:20 AM, in the kitchen, revealed the facility owner entered the kitchen through a back door, and without washing his hands, retrieved a styrofoam container sitting on a shelf over the steam table and exited the kitchen through the back door.</p> <p>Observation on 2/8/16 at 11:30 AM, in the kitchen, revealed the entrance and exit area to the dishwashing area was approximately 3 feet wide. Further observation revealed dirty dishes were sitting on the counter beside the dishwasher. Continued observation revealed a dietary worker brought a clean rack of glasses back through the dirty dish area and placed them in a cabinet.</p> <p>Interview with the DM on 2/8/16 at 11:45 AM, in the kitchen, confirmed the facility owner did not wash his hands and the clean dishes were brought through the dirty dish wash area "...because there is no exit from the clean area...have to come back out that way..."</p> <p>Interview with the Administrator on 2/9/16 at 3:30 PM, in the Administrator's office, confirmed "...they are supposed to wash a load of dishes and when that load is done and put away...they are to go get another load to run through the washer...they aren't supposed to do that [bring clean dishes through the dirty area]..."</p>	F 371	<p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Facility Residents have the potential to be affected by this practice. Education was initiated on 2/10/16 by the Interim Director of Nursing for Facility Staff on duty, including Facility Owner, regarding the need to perform hand hygiene when entering the kitchen. Dietary Manager was counseled on 3/1/16 by the Contracted Registered Dietician regarding the need to maintain a sanitary environment in the kitchen by ensuring items/utensils are thoroughly dry prior to storage, and dishes are stored separately from Dietary Manuals. This education also included the need for clean and soiled dishes, utensils, and pots and pans remaining in separate areas.</p> <p><u>Systematic Changes</u></p> <p>Contracted Registered Dietician, along with the Dietary Manager, will conduct a weekly sanitation audit of the kitchen, to include storage of dishes in the cabinet alone- away from other items, maintaining clean dishes in separate area from soiled dishes, and only storing items/utensils after thoroughly dried. RD, DM, and Dietary Staff will be observant of any staff/visitors entering the kitchen to ensure hand hygiene is performed. Mandatory Staff Meeting was held on 2/10/16 for Dietary Staff regarding the need to maintain a sanitary environment in the kitchen by ensuring items/utensils are thoroughly dry prior to storage, dishes are stored separately from other items, and requiring any staff/visitor entering the kitchen to perform hand hygiene.</p> <p>Continue</p>		

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F 371		F 371	<p><u>Systematic Changes (Continued)</u></p> <p>Also, maintaining clean and soiled dishes, utensils, and pots and pans in a separate area, and the process to accomplish this, was addressed. This in-service will be repeated by the DM on 3/10/16 to ensure Dietary Staff is educated. Staff Meeting was held on 2/16/16 and 2/17/16 by Interim Director of Nursing for Facility Staff regarding the need to perform hand hygiene when entering the kitchen. Staff was encouraged to knock on the door and allow Dietary Staff to retrieve what is needed/requested. Newly-hired Dietary Staff will be educated by Dietary Manager regarding the need to maintain a sanitary environment in the kitchen by ensuring items/utensils are thoroughly dry prior to storage, dishes are stored separately from other items, clean and soiled dishes, utensils, and pots and pans remaining in a separate area, and requiring any staff/visitor entering the kitchen to perform hand hygiene.</p> <p><u>Monitoring</u></p> <p>A weekly Sanitation Audit of the kitchen will be performed by the Contracted Registered Dietician and the Dietary Manager to ensure a sanitary environment in the kitchen is maintained by ensuring items/utensils are thoroughly dry prior to storage, dishes are stored separately from other items, clean and soiled dishes, utensils, and pots and pans remaining in a separate area, and requiring any staff/visitor entering the kitchen to perform hand hygiene.</p> <p>Continue</p>	

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F 371		F 371	<u>Monitoring (Continued)</u>  The results of these weekly audits will be presented to the monthly Quality Assurance Performance Improvement Committee for review and recommendations. This will be an on-going weekly audit, indefinitely. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.		3/15/16

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F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p><u>Corrective Actions for Targeted Residents</u></p> <p>Residents #73 and #99 have shown no outward ill-effects from this practice. LPN #1 was counseled and received verbal disciplinary action on 2/10/16 by the Interim Director of Nursing regarding the need to perform hand hygiene before donning gloves, after doffing gloves, before and after contact with a resident, after contact with resident-contaminated supplies, and prior to disinfecting resident-contaminated equipment such as a glucometer.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Facility Residents have the potential to be affected by this practice. No residents have shown ill-effects from this practice. C.N.A. #1 was counseled and received verbal disciplinary action on 2/10/16 by the Interim DON regarding the need to perform hand hygiene between each resident contact when delivering meal trays and assisting residents with dining.</p> <p><u>Systematic Changes</u></p> <p>Hand-sanitizing dispenser in the Activity/Dining Room was re-located to a more user-friendly convenient location for the Nursing staff on 2/11/16 by the Maintenance Director.</p> <p>Continue</p>		

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F 441	<p>Continued</p> <p>Based on facility policy review, observation, and interview, the facility failed to ensure hand hygiene during a blood glucose check for 2 residents (#77 and #99) of 2 residents reviewed and during a meal tray pass for 2 residents of 12 residents observed.</p> <p>The findings included:</p> <p>Review of a facility policy titled Hand Hygiene dated 9/08 revealed "...All employees shall utilize proper hand hygiene for each of the following conditions...before performing invasive procedures...before and after administering treatments...before preparing or serving food...after contact with a Resident...After contact with Resident-contaminated supplies and equipment...after contact with blood...broken skin or after handling any item potentially contaminated with any Resident's blood...NOTE: The use of gloves does not replace hand hygiene. Once gloves are removed, proper hand hygiene should be performed..."</p> <p>Observation of a blood glucose test for Resident #73, obtained by Licensed Practical Nurse (LPN) #1 on 2/8/16 at 11:50 AM, revealed LPN #1 did not wash the hands before donning gloves, after doffing the gloves or before cleaning the blood glucose monitor. Continued observation of a blood glucose test for Resident #99, obtained by LPN #1 on 2/8/16 at 11:55 AM, revealed LPN #1 did not wash the hands before donning new gloves, after doffing the gloves or before cleaning the blood glucose monitor.</p> <p>Interview with LPN #1 on 2/8/16 at 12:00 PM, in Hensley Hall, confirmed LPN #1 did not wash the hands between, before or after obtaining the</p>	F 441	<p><u>Systematic Changes (Continued)</u></p> <p>Mandatory Staff Meeting was held on 2/10/16 by the Interim DON for Nursing Staff to address the need for performing proper hand hygiene after contact with a resident, before and after donning and doffing gloves, after contact with resident-contaminated supplies and equipment, after handling an item potentially contaminated with resident's blood, and before preparing or serving food, per Facility Policy. This in-service was repeated on 3/1/16 by the Interim Director of Nursing to ensure Nursing Staff is educated. In addition, during their monthly facility compliance visit, the Contracted Consultant Pharmacist will observe nurses performing blood glucose tests to ensure compliance with infection control practices. Also, monthly, the Contracted Registered Dietician will observe the dining program of meal tray pass on the hallways and in the Dining Room to ensure proper hand hygiene is being performed between each resident contact when delivering meal trays and assisting residents with dining. Newly-hired Nursing Staff will be educated by the DON during their orientation period regarding the need for performing proper hand hygiene after contact with a resident, before and after donning and doffing gloves, after contact with resident-contaminated supplies and equipment, after handling an item potentially contaminated with resident's blood, and before preparing or serving food, per Facility Policy.</p>		

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F 441	<p>Continued blood glucoses.</p> <p>Interview with the interim Director of Nursing (DON) on 2/9/16 at 4:08PM, in the DON office, confirmed "...should wash hands between patients..."</p> <p>Observations of staff serving meal trays on 2/8/16 at 12:05 PM, in the activity/dining room, revealed Certified Nursing Assistant (CNA) #1 serving meal trays to 2 residents of 12 residents in the activity/dining room. Further observation revealed CNA #1 carried a meal tray to one resident, uncovered the plate, seasoned the food, adjusted the resident's wheelchair to the table, and without washing or sanitizing his hands, returned to the food cart. Continued observation revealed CNA #1, without washing or sanitizing his hands, carried a meal tray to a second resident, delivered it to the table, uncovered the plate, seasoned the food, adjusted the resident's chair at the table, touched his own hair, and then returned to the food cart, without washing or sanitizing his hands, and opened the food cart to deliver another resident's tray.</p> <p>Interview with CNA#1 on 2/8/16 at 12:10 PM, in the hallway beside the restorative dining room, confirmed he had not washed or sanitized his hands after delivering food trays to the two residents, and confirmed he was preparing to deliver a food tray to a third resident without washing or sanitizing his hands. Further interview with the CNA revealed he knew he was supposed to wash his hands but was "hurrying and forgot."</p> <p>Interview with the DON on 2/9/16 at 4:00 PM, in her office, confirmed staff must wash or sanitize their hands between contact with residents when</p>	F 441	<p><u>Monitoring</u></p> <p>A weekly observation audit of nurses performing blood glucose tests will be conducted by the DON to ensure Nursing Staff is practicing proper hand hygiene before and after procedure, after contact with resident-contaminated supplies or equipment, before and after donning and doffing gloves, and after handling items potentially contaminated with resident's blood. A weekly observation audit will be conducted by the Assistant Director of Nursing of residents' meal tray pass to ensure staff is performing proper hand hygiene between each resident contact when delivering meal trays and assisting residents with dining. The results of the audits for appropriate hand hygiene being performed by Nursing Staff with the cleaning of glucometers and during the delivery of meal tray/assisting with residents' dining will be presented by the DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	3/15/16

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F 441	Continued	F 441			
F 467 SS;D	<p>483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC</p> <p>The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate outside ventilation during smoking times, resulting in the smell of cigarette smoke in the facility, for 1 of 3 halls.</p> <p>The findings included:</p> <p>Observation on 2/8/16 at 10:35 AM, revealed there was a smell of cigarette smoke on Durham hall (around two corners and down a corridor from the smoking area) at the shower room across from room 10.</p> <p>Observation on 2/8/16 at 1:35 PM, revealed there was a smell of cigarette smoke at the Durham nursing station (around the corner from the smoking area). Continued observation of the outside smoking area revealed 3 residents sitting near the door smoking.</p> <p>Observation of the smoking area on 2/9/16 at 1:53 PM, revealed 3 residents and 1 staff member smoking. Continued observation revealed a smell of cigarette smoke directly in front of the door to the smoking area.</p>	F 467	<p><u>Corrective Actions for Targeted Residents</u></p> <p>No Facility Residents have shown outward ill-effects from this practice. Alert residents residing on the Durham Hallway were interviewed by the Social Services Director on 2/26/16 inquiring if the residents were experiencing the smell of cigarette smoke in their rooms. No residents interviewed by SSD had an issue with, or confirmed, smelling cigarette smoke recently or currently.</p> <p><u>Identification of Other Residents with Potential to be Affected</u></p> <p>Residents residing on the Durham Wing have the potential to be affected by this practice. After investigation, the air curtain for the door leading to the Smoking Area had been disabled. On 2/22/16, the Contracted Licensed Electrician installed a new switch for the air curtain preventing disablement by staff. The fan now will remain on, blowing smoke outward, while the door to the Smoking Area is held open allowing residents to enter and exit.</p> <p><u>Systematic Changes</u></p> <p>Staff Meeting was held on 2/16/16 and 2/17/16 by the Interim DON to educate Facility Staff to be observant of the smell of cigarette smoke being present on the Durham Hallway and Nurse's Station, and if present, report this to the Facility Maintenance Director.</p> <p>Continue</p>		

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F 467	<p>Continued</p> <p>Observation on 2/9/16 at 3:10 PM of the smoking area revealed 7 residents and 1 staff member smoking. Continued observation at the Durham Nursing station revealed there was a smell of cigarette smoke at the station.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 2/9/16 at 3:15 PM, at the Durham nursing station, confirmed "...have to go around the corner a lot to get away from the smell..."</p> <p>Interview with the Social Worker on 2/9/16 at 3:50 PM in the hallway outside the Director of Nursing (DON) office confirmed "...if the wind is blowing like it was yesterday, you can smell it at the nursing station..."</p> <p>Interview with the Maintenance Director on 2/9/16 at 4:05 PM, in the maintenance office, confirmed if the door is held open to get the wheelchairs in and out of the smoking area, then smoke is "sucked" in and can be smelled at the nursing station which is approximately 60 feet away from the smoking area.</p>	F 467	<p><u>Systematic Changes (Continued)</u></p> <p>Staff was instructed that the door leading to the Smoking Area is to remain closed at all times except when transporting residents through the doorway. This in-service was repeated on 3/1/16 by the Interim DON to ensure Facility Staff have been educated. Newly-hired Facility Staff will be educated by the Maintenance Director during their orientation period regarding being observant of the smell of cigarette smoke being present on the Durham Hallway and Nurse's Station, and if present, report this to the Facility Maintenance Director. Also, the door leading to the Smoking Area remaining closed at all times, except when transporting residents through the doorway, will be addressed for newly-hired employees.</p> <p><u>Monitoring</u></p> <p>A weekly audit will be conducted by the Maintenance Director ensuring the air curtain for the doorway leading to the Smoking Area is functioning properly. The results of this audit will be presented to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until desired threshold of 100% compliance is met for 3 consecutive months; then quarterly. The Quality Assurance Performance Improvement (QAPI) Committee consists of the Executive Director, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>		3/15/16